WESTON MEDICAL
HEALTH & WELLNESS

Clinic Weight Loss Form

Personal Details:					
Last Name:		First Name:		Middle Name:	
Name you prefer to be called:					
Patient Address:					
City:		State:		Zip:	
Email Address:		Phone Number:			
Birthdate:		Age:		Sex: ☐ M ☐ F	
How did you hear about us?					

In Case of Emergency:					
Name:		Relationship:		Phone:	
Patient's Spouse:				Phone:	
Family Physician:				Phone:	

Financial Policy:

Thank you for selecting Weston Medical Health & Wellness for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept All Major Credit Cards and HSA.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature:		Date:	

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HEALTH & WELLNESS

Present Status:

1. Are you in good health at the present time to the best of your knowledge? ☐ Yes ☐ No
Explain a "no" answer:

2. Are you under a doctor's care at the present time? ☐ Yes ☐ No
If yes, for what?

3. Are you taking any medications at the present time? ☐ Yes ☐ No
Prescription Drugs: List all

Drug:	Dosage:

Over-the-Counter medications, vitamins, supplements: List all ☐ Yes ☐ No

Product:	Dosage:

4. Any allergies to any medications? ☐ Yes ☐ No
Please list:

5. History of High Blood Pressure? ☐ Yes ☐ No

6. History of Diabetes? ☐ Yes ☐ No

At what age:

7. History of Heart Attack or Chest Pain or other heart condition? ☐ Yes ☐ No

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HEALTH & WELLNESS

8. History of Swelling Feet			☐ Yes	☐ No
9. History of Frequent Headaches?			☐ Yes	☐ No
Migraines? ☐ Yes ☐ No	Medications for Headaches:			
10. History of Constipation (difficulty in bowel movements)?			☐ Yes	☐ No
11. History of Glaucoma?			☐ Yes	☐ No
12. History of Sleep Apnea?			☐ Yes	☐ No
13. Gynecologic History:				
Pregnancies:	Number:		Dates:	
Natural Delivery or C-Section (specify):				
Menstrual:	Onset:		Duration:	
Are they regular: ☐ Yes ☐ No				
Pain associated: ☐ Yes ☐ No				
Last menstrual period:				
Hormone Replacement Therapy: ☐ Yes ☐ No				
What:				
Birth Control Pills: ☐ Yes ☐ No				
Type:				
Last Check Up:				

14. Serious Injuries: ☐ Yes ☐ No

Specify (list all)	Date

15. Any Surgery: ☐ Yes ☐ No

Specify (list all)	Date

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16. Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Glaucoma:	☐ Yes	☐ No	Who:	
Asthma:	☐ Yes	☐ No	Who:	
Epilepsy:	☐ Yes	☐ No	Who:	
High Blood Pressure	☐ Yes	☐ No	Who:	
Kidney Disease:	☐ Yes	☐ No	Who:	
Diabetes:	☐ Yes	☐ No	Who:	
Psychiatric Disorder	☐ Yes	☐ No	Who:	
Heart Disease/Stroke	☐ Yes	☐ No	Who:	

Past Medical History: (check all that apply)

☐ Polio	☐ Measles	☐ Tonsillitis
☐ Jaundice	☐ Mumps	☐ Pleurisy
☐ Kidneys	☐ Scarlet Fever	☐ Liver Disease
☐ Lung Disease	☐ Whooping Cough	☐ Chicken Pox
☐ Rheumatic Fever	☐ Bleeding Disorder	☐ Nervous Breakdown
☐ Ulcers	☐ Gout	☐ Thyroid Disease
☐ Anemia	☐ Heart Valve Disorder	☐ Heart Disease
☐ Tuberculosis	☐ Gallbladder Disorder	☐ Psychiatric Illness
☐ Drug Abuse	☐ Eating Disorder	☐ Alcohol Abuse
☐ Pneumonia	☐ Malaria	☐ Typhoid Fever
☐ Cholera	☐ Cancer	☐ Blood Transfusion
☐ Arthritis	☐ Osteoporosis	☐ Other:

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Nutrition Evaluation:					
1. Present Weight:		Height (no shoes):		Desired Weight:	
2. In what time frame would you like to be at your desired weight?					
3. Birth Weight:		Weight at 20 years of age:		Weight one year ago:	
4. What is the main reason for your decision to lose weight?					
5. When did you begin gaining excess weight? (Give reasons, if known):					
6. What has been your maximum lifetime weight (non-pregnant) and when?					

7. Previous diets you have followed:	Give dates and results of your weight loss:

8. Is your spouse, fiancee or partner overweight? ☐ Yes ☐ No					
9. By how much is he or she overweight?					
10. How often do you eat out?					
11. What restaurants do you frequent?					
12. How often do you eat “fast foods?”					
13. Who plans meals?		Cooks?		Shops?	
14. Do you use a shopping list? ☐ Yes ☐ No					

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15. What time of day and on what day do you usually shop for groceries?					
16. Food allergies:					
17. Food dislikes:					
18. Food(s) you crave:					
19. Any specific time of the day or month do you crave food?					
20. Do you drink coffee or tea? ☐ Yes ☐ No	How much daily?				
21. Do you drink cola drinks? ☐ Yes ☐ No	How much daily?				
22. Do you drink alcohol? ☐ Yes ☐ No					
What?		How much daily?		Weekly?	
23. Do you use a sugar substitute?		Butter?		Margarine?	
24. Do you awaken hungry during the night? ☐ Yes ☐ No					
What do you do?					
25. What are your worst food habits?					
26. Snack Habits:	What?		How much?		When?
27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:					
28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:					

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29. Smoking Habits: (answer only one)

- ☐ You have never smoked cigarettes, cigars or a pipe.
- ☐ You quit smoking _____ years ago and have not smoked since.
- ☐ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without Inhaling smoke.
- ☐ You smoke 20 cigarettes per day (1 pack).
- ☐ You smoke 30 cigarettes per day (1-1/2 packs).
- ☐ You smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast	Typical Lunch	Typical Dinner
Time eaten:	Time eaten:	Time eaten:
Where:	Where:	Where:
With whom:	With whom:	With whom:

31. Describe your usual energy level:

32. Activity Level: (answer only one)

- ☐ Inactive - no regular physical activity with a sit-down job.
- ☐ Light activity - no organized physical activity during leisure time.
- ☐ Moderate activity - occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- ☐ Heavy activity - consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..
- ☐ Vigorous activity -participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

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33. Behavior style: (answer only one)
☐ You are always calm and easygoing. ☐ You are usually calm and easygoing. ☐ You are sometimes calm with frequent impatience. ☐ You are seldom calm and persistently driving for advancement. ☐ You are never calm and have overwhelming ambition. ☐ You are hard-driving and can never relax.
34. Please describe your general health goals and improvements you wish to make:

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

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Weight Loss Program Consent Form

I _____ authorize Weston Medical Health & Wellness and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Date: _____ Time: _____

Witness: _____ Patient: _____

(Or person with authority to consent for patient)